

Episode: Ethics Talk – Measuring Racism in Academic Health Centers

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TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff.

Research on institutional racism, that is, the practices and policies that disadvantage individuals who are not part of society's dominant groups, has declined in the 2000s. While research on structural racism, how racial discrimination expresses through social infrastructure, has become more popular. This shift in focus from institutional racism to structural racism suggests how deep seated the roots of American racism are, and also suggests the importance of developing strategies for change attendant to the multiple levels on which racism manifests.

DR PARIS ADKINS-JACKSON: By working together to limit resources or provide an abundance of resources to one group, these institutions become complicit in an operation of structural racism. Additionally, these institutions become intermediaries of structural racism, as it's through their bodies that discriminatory policies are implemented.

HOFF: That was Dr Paris Adkins-Jackson, a multidisciplinary health researcher who uses mixed data to model multilevel assessments of racism at the Care Research Center at Massachusetts General Hospital, Harvard Medical School in Boston, Massachusetts. She joined us this month to discuss her and her coauthors, Dr Rupinder Legha and Kyle A. Jones', article in which they outline a project to measure institutional racism at academic health centers in the first of our two-part issue on racial and ethnic health equity and the United States.

Dr Adkins-Jackson, thank you so much for joining me.

ADKINS-JACKSON: Thank you for having me.

HOFF: As you know, as a researcher in this field, the evidence of racial, ethnic, and structural barriers to health equity is already abundant. And yet few organizations are investing or being accountable for their roles in making health inequity worse. You suggest that measuring institutional racism is needed to promote transparency and real accountability. You also suggest that organizations' self-studies should be required for accreditation and overseen by the Joint Commission and the Centers for Medicare and Medicaid Services. Why is that?

ADKINS-JACKSON: Because everyone wants credit for well intentions instead of credit for equitable wellness. I could go deeper on this, but I mean, it's really that institutional racism goes beyond the individual actions of one or two. It is a system in which people with differential privilege sign over their autonomy and become actors in a system of racism. And somehow, when we come to conversations about accountability, individuals believe we're talking about what they do after hours or how much concern they personally have for

the state of the world or even where they volunteered over summer. We are not talking about individuals. We're talking about systems that use individuals to perform racism.

So, instead of convincing individuals to change systems they cannot, I'd rather spend my time implementing procedures, such as measuring institutional racism, that will enforce or force the institution to self-monitor while allowing all of us to monitor as well. I mean, imagine the powers of the Joint Commission and the Centers for Medicare and Medicaid monitoring institutional racism over time. Being this transparent in the racism of institutions can inspire change. But, you know, let's think of it as a natural experiment. Will apathy and busyness moderate our discontent with seeing the level of institutional racism in academic health centers? Or is there a path where observing those values year after year after year will force reform? Let's see. If only some academic health centers were bold enough to test this experiment, I would love to see what comes of it.

HOFF: And you noted in your article, I believe, as far as you were aware, there's no institutions currently undertaking projects like this. Has that developed since the writing of the article, do you know?

ADKINS-JACKSON: No, it has not. Or I'm not aware. If they have, they haven't publicized, because that's a different story.

HOFF: Sure.

ADKINS-JACKSON: So, there might be internal self-studies occurring, but they're not particularly publicizing what they're doing. Because you can imagine how embarrassing it is.

HOFF: [chuckles] Right.

ADKINS-JACKSON: But that's why science sort of is powerful, that it can, you know, in institutional racism, science cooperates with policy to produce racism. But if you turn it on its head or you reframe it in a different direction, then you get to a place where you can use science to engineer change. And that's exactly what the article is doing. It's saying, you know what? It's sexy now. It's cool now. Be transparent about your racism. You're okay now. You're in the century where you can do that. So, let's do that proudly, and make change this as we go along. And so, in this way, science is sort of giving the cute shoulder to policy to go, let's make it happen, and let's make changes for communities.

HOFF: Managing the volume of data that's needed to assess institutional racism seems like a massive undertaking. And as you've mentioned previously, you suggest measuring objective things like the amount of time clinicians spend with patients of color or the specific resources distributed to patients of color. You also suggest gathering subjective data points such as patients' reports of clinicians' conversational pace and tone and their body language and their perception of the shared decision-making process. So, what role should patients' own health care experiences have in health equity research? Because they certainly should be included. And how should these data be gathered?

ADKINS-JACKSON: So, there are two things there that I want to respond to. So, the first is managing the data is easy if you value it.

HOFF: Mm.

ADKINS-JACKSON: There are many creative ways of doing so, including having clinical students conduct evaluations every year. This is the stuff that isn't rocket science. However, if brainstorming how to do this, you feel some resistance, that is something that needs to be explored. That reluctance needs to be placed in a welcoming setting where it can be disentangled, and the individual can really work on their personal desire to protect, block, or discontinue something that is flowing toward justice. So, we must carry an attitude that it is possible. Because the energy of that thought process will allow us to either come up with the ways or identify the people who could come up with the creative ways so that we can continue to be transparent and honest about the level or the integrity of care that we intend to offer our fellow citizens.

But it is not acceptable to gatekeep justice. And so, wherever we find individuals doing this, we need to allow them the space to really interrogate those particular feelings. Because there is a flow toward justice in this nation, and it's not appropriate to stand against it. We've got to sort of get with the energy of the times and just flow with that energy so that we all can feel like we're a part of this nation.

But to the actual question you asked: so, we included qualitative ways of gathering and examining institutional racism because we recognized quantitative data can be limited. It can miss the mark.

HOFF: Right.

ADKINS-JACKSON: So, our goal is truly to ensure that these institutions get better. We want academic health centers to improve and to truly help everyone. So, sometimes data must be qualified. So, we propose at each level a qualitative way of getting at this data so that it can be in combination with the quantitative data. So, we proposed at the individual level for patients to provide assessments of their experiences.

Imagine there is no statistical difference between groups on the amount of time a clinician spends with a patient, yet there are differences in health outcomes.

HOFF: Mmhmm.

ADKINS-JACKSON: It would be easy to assume that there is something wrong with one of the groups, or something about one of the groups is different from the other instead of really looking at the point of measure as a unit of bias.

HOFF: Hmm.

ADKINS-JACKSON: But you would know this if you diversified your measures. If you had patient responses, then they would tell you, it's not the amount of time I actually spend with my clinical provider, but it's the quality of that time, the tone of the conversation, the amount of information they shared. And I recently experienced this with a visit to E.R. last week where my doctor just was not good at explaining things. But my aftercare summary was 20 pages long, and it included all these conditions that the doctor and I had never even discussed.

HOFF: Hmm.

ADKINS-JACKSON: But without my perspective, I'm sure the electronic health record read that the physician went over all this stuff with me, and I seemed to understand what was

happening. But without my record, that information is skewed. So, this is why patients must be involved: so we can hear multiple stories. We can appropriately locate the issue, because it might've been that the physician assumed that I was competent and that they could just print me out a summary of their concerns for me, and I would read it and move on without talking to me. So, there's all these things that happen. So, we need those multiple stories so we can really get at the issue.

As for who gathers this, get creative. Local schools, volunteer groups, clinical students, administrators that have limited interactions with the community. As I said, if you desire to find a way, you shall.

HOFF: How do you propose to measure the next level of institutional racism, so to speak, that is interorganizational racism, in a qualitative way? What are some resources that academic health centers have that they could put to use in gathering this data?

ADKINS-JACKSON: So, we propose using your clinical students. So, some of the literature—this is interesting for me to talk about, because I like going back and forth with people about this literature—so some of the literature is suggesting that where implicit bias sort of starts, where you really start seeing it as a problem. And so, first-year medical students are coming in with limited implicit bias. Third year, it's at similar levels as practicing physicians. And so, you're like, what is happening in those few years with medical students' implicit bias? I mean, I can think of a couple of things: the curriculum.

HOFF: [chuckles] Right.

ADKINS-JACKSON: But one thing in particular third year's occurring, which is they're getting clinical experience.

HOFF: Mm.

ADKINS-JACKSON: And it's something about clinical encounters that sort of force these experiences. And this is why interorganizational level is important, period, and why we measure implicit bias across all of it. Because the physicians have not decided that eight to 12 minutes is the standard amount of time to have care. An institution has decided that. So, what is a physician to do in that moment or a clinician to do? They are to, in eight to 12 minutes, determine things for you that maybe you have not communicated. Okay, well, I see they're overweight, Okay, maybe they have back pain. Okay, so maybe this is about their weight. [laughs]

HOFF: Mm.

ADKINS-JACKSON: They're making all these implicit judgments about an individual. And so, what is interesting is that perhaps this is happening for the students. And you'll hear a lot of students say they had problems during this year because they were thinking one thing about the patient: "Well, maybe it's not about their weight." But their supervisor is like, "You're taking too much time. We need to do X, Y, and Z and get out of here."

HOFF: Mmhmm.

ADKINS-JACKSON: And so, they're pressured to adapt to a way of practicing medicine that may not be natural to them. So, what if we use first- or second-year students or even people in that particular process interrupted that process and had them do evaluations of a

clinical space? It will provide us this qualitative means of understanding what's happening, but it also would sort of work towards the infrastructure of it. Because it would disrupt this process of adapting to a way of doing that is not producing the kind of health outcomes we want. So, that's why we got creative with this, because, remember, the goal is still to improve academic health centers. So, we're not trying to just say, "Let's measure what you're doing wrong." We're saying, "Let's really figure out the areas of improvement and how we can handle it from within, use our next round of trainees to understand where the complications lie and perhaps where they may do it differently."

We also propose using community health workers to do those kind of assessments as well.

HOFF: Sure.

ADKINS-JACKSON: Because they're a part of the whole encounter for community.

HOFF: Right, right. Yeah. And that's actually one of the things I was thinking about when I first read your article, is that these measures, especially of interpersonal encounters and requiring, anything that requires clinicians to do more documentation, is likely to get pushback in scenarios where they're already, like you said, very pressured to move quickly. So, I like this idea of kind of incorporating all of these other organizations and community members and things like that to sort of build out this project.

ADKINS-JACKSON: Mmhmm.

HOFF: I think that's a good idea.

ADKINS-JACKSON: And they actually will be excited to participate because how much are they left out of the equation?

HOFF: Yeah, exactly.

There's a long history of academic health centers mistreating members of minoritized communities, and that's certainly been shown to carry on to the present. The COVID-19 pandemic, for example, has laid the country's racial and ethnic inequities bare for all to see. So, it's no wonder that patients of color remain distrustful of health care organizations and professionals. You suggest that there's hope here, though, that requiring and standardizing organizational measures of institutional racism can help address mistrust by generating transparency and organizational accountability. Can you talk a little bit more about how you see this relationship between health care organizations and individual patients and families playing out?

ADKINS-JACKSON: Sure. And it's going to be radical. [laughs]

HOFF: Go for it. Love it.

ADKINS-JACKSON: So, just a heads up. I love this question. So, let me start with lack of trust, i.e. distrust, i.e. medical mistrust, i.e. vaccine hesitancy. There are many names for it these days, but the feeling does not differ for communities. So, we researchers, trialists, medical institutions, clinicians must recognize that the story must start with social determinants. The same determinants that influence access to care, treatment outcomes,

disease progression also influence the relationships we as actors within academic health centers have with the community.

For example, I was having conversations in community during—well, I love to say during COVID like it's over—[laughing] during COVID-19 about potentially taking the vaccine. I, through trust, was able to get community members to consider potentially engaging a trial. From the strength of their trust of me, they considered it. Until the story broke about sterilizations at the U.S.-Mexico border.

HOFF: Yeah.

ADKINS-JACKSON: Now I was in community with Black African-Americans about this topic. It is not Black African-Americans, or there were not Black African-Americans that were sterilized at the U.S.-Mexico border. So, some people will make the assumption that because it's not the same groups that it doesn't impact them. But Black women were outraged at hearing the story about sterilizations at the border because number one, it's an injustice. But number two, they can remember a history where the same thing was happening to Black women.

HOFF: Right.

ADKINS-JACKSON: So, for them, that closed up all conversations about engaging in a COVID-19 vaccine trial.

HOFF: Hmm.

ADKINS-JACKSON: Sterilizations impacted participation in a COVID-19 trial. That is the dynamic my colleagues failed to understand.

HOFF: Mm.

ADKINS-JACKSON: I've seen physicians complain on Twitter about trying to convince BIPOC people of something and the person not trusting them, even though they're a physician of color. Of course not. Do they think their skin would buy more trust than the distrust from a system that has continuously mistreated them? My point is that if we want to truly reduce distrust, mistrust, we as a clinical community have to work against social determinants. Not just offer transportation to get care or incentives to be a part of our studies. We as a clinical community have to be advocates for justice.

That means we have to be strategic. We have to help our colleagues reform, or burn down when necessary, the institutions from within. We have to help our colleagues show up for community to support endeavors. We have to help our colleagues speak against injustice and institutional racism. And I state it this way because some of our colleagues have been doing this alone. We've been considering their efforts to be problem making. But what if we reframed it? I'm all about my reframing.

HOFF: [chuckles]

ADKINS-JACKSON: Maybe their efforts are advocacy on the part of communities. Maybe your colleagues are lending their privilege and voices in the service of individuals without. Maybe all that is needed is a clinical community, not a few individuals, but a community,

an army of employees to say, “We will no longer treat patients and ignore the influence of social determinants on them.”

Imagine communities watching their medical facilities do that. That would be revolutionary. Having all of us sort of advocate for them, the things that actually produce quality care and a good life for them, watching all of us stand up against those social determinants. I mean, I can tell you now I have Kaiser. If Kaiser showed up on Capitol Hill to confront Republicans about their campaign against the Affordable Care Act, I might not roll my eyes every time I have to make a payment.

HOFF: [laughs]

ADKINS-JACKSON: I might actually be [inaudible] that payment. [laughs]

HOFF: Yeah.

ADKINS-JACKSON: I might actually give that payment with joy.

But I think that’s the way to reform our relationships. We can’t keep asking more of patients and families: like, if you all show up for us, if you participate in our studies, if you this, if you that. No, what are we going to do besides just collect data and tell you what to do? Let us show up for you. Let us show you that we understand what is truly impacting your health.

HOFF: That all sounds true. It sounds like it also complicates the vision of patient mistrust or distrust being ameliorated at all by an individual clinician. So, when you have a clinician working with a patient who has some level of mistrust, even if it’s not mistrust in that individual physician, for example, what can you do, I guess, is my question? Since it seems like we can’t necessarily expect individual clinicians to even be able to address the mistrust that’s based in structural inequities.

ADKINS-JACKSON: Mmhmm, mmhmm. Yeah! No, no, no. I think the root of the issue is where our expectations lie. Our expectations lie with some semblance of what can I individually do at this moment for this patient? Instead of recognizing that these things are systematic. And once we get into that vein of thinking, where things are systematic, that everything I do against this system will impact mine and other patients. And that’s what I’m asking us to do. We will always do things that engage our individual community members toward better health. But what are we doing systemwide to ensure that we don’t have to work this hard?

I mean, clinicians are having to monitor every single thing in an individual encounter because of all of these legal ramifications. What if we reform the system so that everyone is working for that patient? It just takes a different reframe of how we see our goals. If the individual patient did not acquire their mistrust or distrust from that physician, then why would there ever be the expectation that this physician is going to, like you said, ameliorate that distrust? I mean, let’s stop thinking so small. Why don’t we get rid of the distrust at the system level by getting rid of the way that these social determinants influence that distrust? [mellow theme music returns] Why don’t we prove the trust that they deserve?

HOFF: Dr Adkins-Jackson, thank you so much for joining me today. It was a pleasure to have you on.

ADKINS-JACKSON: Thank you!

HOFF: That's our episode for this month. Thanks to Dr Adkins-Jackson for joining us. Music was by the Blue Dot sessions. To read Dr Adkins-Jackson's article, which she coauthored with Dr Rupinder Legha and Kyle Jones, and to read the rest of our February issue on racial and ethnic health equity in the United States, visit our website, JournalofEthics.org. For all of our latest news and updates, follow us on [Twitter](#), [Facebook](#) @JournalofEthics and our [YouTube channel](#). And be sure to join us next month for an interview with LaShyra Nolen. Talk to you then.